www.lungandsleepcenter.com

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**Patient Printed Name:** ______________________________ DOB _______________

## CONSENT TO TREAT

______**(initial) I request and authorize outpatient care as my physician, his/her assistant or designee may deem necessary or advisable.**

## INSURANCE

______**(initial)** I understand that it is my responsibility to know my insurance and the rules of payment. If my insurance does not pay for services, I understand it is my sole responsibility and I will obtain any referrals required.

## PRIVACY PRACTICE ACKNOWLEDGEMENT

______**(initial)** The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practices legal duties with respect to my information. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

## I give Lung and Sleep Center permission to discuss my medical records with the following persons:

Name: __________________________ Phone: ____________ Relation: ____________

Name: __________________________ Phone: ____________ Relation: ____________

Name: __________________________ Phone: ____________ Relation: ____________

**Signature:** ________________________________ **Date:** ______________________